MS-2126
Rev 07-07

NOTIFICATION OF FACILITY ADMISSION/DISCHARGE

1. RESIDENT INFORMATION

Name: _____ SSN: _____ Sex: _____

Date of Birth: _____ Client ID #: _____

Responsible Person or Agency: _____ Relationship: _____

Responsible Person Address: _____

II. FACILITY INFORMATION

Facility Name/Location: _____ Phone: _____

Name of Agency/ Person Placing Resident: _____ Facility Fax: _____

CARE or Screening Completed? Yes ☐ Date _____ No ☐ Reason: _____

Administrator's Signature(or Designee): _____ Date: _____

III. FACILITY PLACEMENT/DISCHARGE

A. ADMISSION 1. Admission Date: _____ Anticipated Length of Stay: _____

2. Admitted From (check one):

☐ NF ☐ ICF/MR ☐ NF/MH ☐ Hospital
☐ Private Home ☐ Swing Bed ☐ State Institution
☐ Assisted Living ☐ Other _____

If admitted from facility, name of facility: _____

3. Pay Status on Admission (check one): ☐ Private Pay ☐ Medicare or Private Insurance ☐ Medicaid ☐ Other _____

4. Current Level of Care in Your facility:

☐ Nursing Facility (NF SN) ☐ NF - Mental Health (NF MH) ☐ State Hospital - MR (SH SD)
☐ Swing Bed (NF SB) ☐ Head Injury/Rehb. (NF HI) ☐ State Hospital - MH (SH SM)
☐ PRTF (BF MH) ☐ ICF/MR (NF SD)

B. DISCHARGE INFORMATION

1. Discharged to: (check one) 2. Discharge Date: _____ 3. Date Deceased: _____

☐ Private Home ☐ Facility ☐ Swing Bed ☐ Assisted Living
☐ Hospital ☐ Other _____

3. If discharged to facility or hospital, name of facility: _____ Level of care: _____

IV. HOSPITAL LEAVE (Complete for absences over 30 days only):

Hospital: _____ Date Admitted: _____ Estimated _____

This form must be filed with the local DCF office within 5 working days of the date of admission, discharge, death or hospital leave. Distribution: Original to Facility; Copy to Local DCF Office.

MS-2126 Instructions

1. The facility initiates the MS-2126 under the conditions specified in KEESM 8184.1 within 5 days of the event/request. Specific conditions prompting an MS-2126 include:

    - A medical recipient is admitted or discharged from the facility
    - A resident files an application for medical assistance
    - A resident has been absent from the facility for 30 days or longer
    - A resident changes level of care

2. Sections I and II are always completed. Sections III or IV are completed as necessary.

3. If the resident is in DCF or JJA custody, note this in Section 1 under responsible person/agency. Contact the designated individual in the DCF Regional Service Center if additional information is needed.

4. For PRTF, follow processing guidelines outlined in the appropriate KMAP Provider Manual regarding prior authorization and prescreening.

5. Indicate the results of any required pre-admission screening. It is the responsibility of the admitting facility to ensure these requirements are met. Note: a CARE assessment is NOT required for Swing Bed placements.

6. The facility shall retain the original MS-2126 and submit a copy to the DCF eligibility contact.

7. DCF will notify the facility when payment is approved or denied. The facility will also be notified of the effective date and any applicable patient liability.